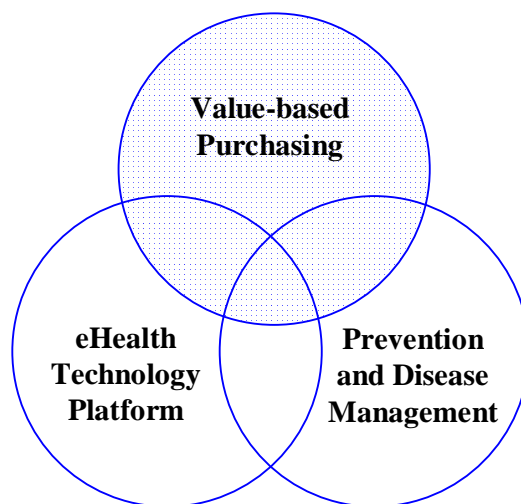


Wisconsin eHealth Action Plan



**eHealth Care Quality and
Patient Safety Board**

Wisconsin **eHealth Care Quality and Patient Safety Board**

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Gary Bezucha, Administrator, Boscobel Area Health Care

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Hugh Zettel, Director, Government and Industry Relations, GE Healthcare

Wisconsin eHealth Action Plan

Workgroup Reports Executive Summaries

December 1, 2006

Wisconsin eHealth Care Quality and Patient Safety Board

Foreword

This document is submitted to Governor Jim Doyle to meet the requirements set out in Executive Order #129, November 2005, creating the eHealth Care Quality and Patient Safety Board and directing the Board to create a five-year plan for statewide adoption of health information technology and health information exchange.

For more information about the Wisconsin eHealth Board and its activities and for copies of this report, visit <http://ehealthboard.dhfs.wisconsin.gov>.

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Table of Contents

CHAPTER 4: SUMMARY OF EHEALTH WORKGROUP RECOMMENDATIONS	1
<i>Patient Care Workgroup – Executive Summary.....</i>	<i>2</i>
<i>Information Exchange Workgroup – Executive Summary.....</i>	<i>10</i>
<i>Consumer Interests Workgroup – Executive Summary.....</i>	<i>17</i>
<i>Financing Workgroup – Executive Summary.....</i>	<i>24</i>
<i>Governance Workgroup – Executive Summary.....</i>	<i>31</i>

Chapter 4: Summary of eHealth Workgroup Recommendations

Under the leadership of the eHealth Care Quality and Patient Safety Board, there have been many activities to engage stakeholders in the creation of this plan including:

- Key informant interviews and an e-survey of stakeholders;
- An assessment of the current use of electronic health record systems and other health information technology in Wisconsin;
- An “eHealth Planning Forum” on May 5, 2006 at the Fluno Center to inform and involve stakeholders in the development of this plan; and
- Listening sessions with health care consumers and providers.

The eHealth Board has made a commitment to a transparent process with meetings open to the public, web casts of key events, and a comprehensive eHealth Board Web site.

Five workgroups were created to develop recommendations to the eHealth Board for this *Action Plan*, each led by a member of the Board:

- Patient Care – Edward Barthell
- Information Exchange – Hugh Zettel
- Consumer Interests – Catherine Hansen
- Financing – Kevin Hayden
- Governance – Frederic Wesbrook

The recommendations from these groups have been woven together to produce this plan and outline the specific activities by year that are described in Chapter 3. This Chapter provides the executive summaries of the five workgroup reports.

The complete report of each workgroup is presented on the eHealth Board Web site (<http://ehealthboard.dhfs.wisconsin.gov>).

Appendix 2 provides a list of the volunteers who participated in the workgroups and the staff who provided support to the workgroups and development of this *Action Plan*.

Patient Care Workgroup – Executive Summary

The Patient Care Workgroup was charged to:

1. Define criteria (such as reach, feasibility and impact) to prioritize the key product types (such as Continuity of Care record or other abstract of medical history information, clinical care – public health business interoperability, e-Prescribe, use of statewide guidelines) and identify and prioritize the key product types to be implemented in the Action Plan.
2. Define use case examples (real-world examples) that are appropriate for the first key products.
3. Develop information on current use of electronic health records in Wisconsin.
4. Identify positive opportunities and barriers to wider adoption of electronic health information systems in all types of medical care settings. Recommend strategies to take advantage of opportunities and overcome barriers to foster statewide adoption.

To accomplish these charges, workgroup members prioritized outcome goals and information products (in collaboration with other workgroups); described a set of specific information products that could produce early value for patients, clinicians and other stakeholders; described the types of regional organizations needed to support such information products and a step-wise fashion in which the work can be approached; described functions that might best be performed at a statewide level; and recommended action to promote the adoption of necessary technology within individual organizations. An inventory of electronic health records and information exchange efforts is underway at the time of this report and will be described in later documents.

Workgroup members first prioritized on the basis of the *urgency* of beneficial changes in health care and public health practice. (The criterion of *feasibility* as opposed to *urgency* was not included in this initial ranking.) A survey was completed by both the Patient Care and Consumer Interests workgroups. Answering in their professional capacities, workgroup members gave highest priority to (in descending order):

- Clinician access to a patient's information *between* (as well as within) health care organizations
- Avoiding preventable hospitalizations
- Preventing medical injuries
- Accessing a common and comprehensive medication list for each patient
- Providing clinical decision support
- Avoiding duplicate procedures
- Enhancing quality management, and
- Increasing inter-provider collaboration for patient care.

The same individuals, answering as patients or as family caregivers, also prioritized (along with many of the above):

- Enabling the creation of patient health records (accessible and controlled by the patient)
- Reducing the repetition of registration and health history information
- Enhancing patient or proxy access to their clinical health records
- Enabling e-visits, and
- Increasing cost-awareness of medications, procedures, etc.

Most of these goals depend on the assembly of a patient's health information from across separate organizations. Several of these priorities require a focus on Health Information Exchange (HIE) *between* organizations more than on the adoption of Health Information Technology (HIT) *within* any individual organization.

Feasibility: The feasibility of addressing the above goals (that were selected on the basis of urgency) was subsequently addressed.

The workgroup concluded that the largest number of highly urgent priorities would be addressed most rapidly by focusing on *clinician* access to information. There are several rationales for this conclusion:

- Clinicians at the point of service are in the best position to improve care quality, safety and efficiency based on better information at the point of service;
- It is much easier to authorize and authenticate licensed health care professionals for Internet access to confidential health information than, for example, to provide the same level of security for members of the general public;
- In the interest of patient-clinician communication and patient education, clinicians often desire to be present when patients access their own health information.

For these reasons, the Patient Care workgroup decided that providing such information to clinicians at the point of care would both provide the greatest value and be most feasible for early HIE development. Once the infrastructure is developed to assemble and deliver a comprehensive summary of a patient's health information for clinicians, it could be reused in many ways for other desired goals, including direct patient access.

This conclusion is not meant to downplay the importance of patient access, review and use of their own health information, tools permitting patients or their guardians to submit information to health care providers, or enhancing clinician-patient communication. Indeed, various Patient Health Record applications are

now provided to patients by health care provider organizations and by health plans. It will be important to link such applications to Health Information Exchanges so they can both benefit from and contribute to the improvement of information access provided by HIE. However, the challenge of validating the identity of millions of patients, of ensuring appropriate physician-patient communication, and of carefully incorporating electronic communication into the workflow of health care delivery argues that these information products be offered to patients by their own providers and plans rather than by HIE organizations in the near term.

The information types listed in Recommendation 3 of this summary were selected as those most important to improving patient care safety, quality and value. Most of the information is potentially available without relying on information from individual providers' Electronic Medical Records (EHRs). For example, much demographic information is available from claims or registration data systems; medication information from pharmacies, claims or pharmacy benefit management databases; etc. Thus summaries of such information can be created and shared with users from many already existing sources. They can also be delivered by many existing methods, including fax, secure Internet portal, or display from within an EHR. Because the adoption of EHR applications is likely to be gradual, and is not an absolute prerequisite to develop useful information products, it does not make sense to wait for universal EHR adoption to begin building Health Information Exchanges (HIE) to assemble and share such important information for a patient's care.

Nevertheless, from the perspective of improving the efficiency and quality of care, it is important that such information ultimately be used *from within* the EHR or other end-user application. Parallel, stand-alone information delivery systems often fail to be consulted, create inefficiencies in workflow, and may not interface with real-time automated clinical decision support systems that can alert clinicians of important, sometimes lifesaving, opportunities to avoid injury or implement prevention. Thus, while many early users may receive HIE information by fax or other technologies, it is critical that the data be increasingly standardized over time, such that it can be imported and exported automatically and used within EHRs and other applications. Similarly, it is important that clinicians and others continue to invest in EHRs and other forms of HIT that are certified to meet such interoperability goals. Indeed, the availability of standardized information feeds from an HIE and the certification of interoperable applications are likely to accelerate adoption of technology in the practice setting. Additional recommendations were also made to help accelerate HIT adoption at the same time that HIE networking is being established.

The workgroup adopted the vision of Connecting for Health and the National Coordinator for Information Technology that at the core of regional Health Information Exchange would be an organization (often referred to as a Regional

Health Information Organization - RHIO) that could help competing stakeholders in a region organize electronic information exchange. Such organizations were felt to be most stable and likely to be self-sufficient at the level of the Medical Trading Area, the natural market within which most referrals, hospitalizations, and other flows of both patients and patient information typically occur. Such an area is the geography in which face-to-face trust can most readily be established and within which the bulk of information is currently exchanged (usually on paper) on a daily basis. The RHIO is the organization through which most HIE services are selected, developed and delivered (although technical implementation might be performed by a contracted third party). Which services are selected would depend on the local use cases and business cases judged to lead to a sustainable business model.

The primary functions of these RHIOs are first, to establish the fundamental infrastructure for information exchange (including the trust, governance and agreements that enable exchange as well as the technical infrastructure) and second, to create exchange services that enable information to flow. Based on these two prerequisites, the RHIO, its members, or third-party organizations can create information products that produce real value for patients or other stakeholders. Several use cases were developed to describe information products likely to produce early value for different types of information exchange stakeholders, including patients, clinicians, health care provider organizations, service providers like laboratories, payers and care managers and public health agencies.

Incremental development is advised at the regional level, selecting early exchange services that:

- Are technically feasible and lay the foundation for later, more complex projects;
- Fall within the information-sharing willingness and trust of major stakeholders (including patients);
- Enable desired information products and value creation; and
- Can generate revenue to fund ongoing operation and future expansion of services.

Although RHIOs are most likely to be regional (sub-state, or potentially even interstate in areas where referrals frequently cross state lines) there is also a role for a statewide service provider whose customers are primarily regional HIEs both inside and outside of Wisconsin. Economies of scale favor centralizing certain business functions at a state level.

Patient Care Recommendations:

1. The highest early priority for information exchange is to provide real-time access to a patient's high-value clinical information, including access to historical data from across all sources of care (a patient-centric summary). The assembly and delivery of such information in this fashion is a prerequisite to achieving many other desired goals.
2. Consumers desire access to electronic health information. It is unlikely that HIEs themselves will be able provide PHR applications directly to consumers in the near-term. However, other organizations (like insurance companies or hospitals) are providing Patient Health Records (PHR) for patient use. These should link to the health information exchanges to receive and contribute information.
3. The highest priority information types for information exchange (not ordered by importance) include the following:
 - **DEMOGRAPHICS**
 - Patient identity/demographics
 - Payer/insurance coverage/eligibility
 - Patient contact-in-emergency
 - Advance directives
 - **CARE HISTORY**
 - Patient visits and hospitalizations
 - Visit/encounter diagnoses
 - Discharge summaries/progress notes
 - Procedures
 - **THERAPEUTICS AND SAFETY**
 - Medications
 - Allergies
 - Immunizations
 - Medical devices and implants
 - **RESULTS**
 - Laboratory and other diagnostic results

Information exchange can opportunistically deploy those classes of information that became available first, so as to provide value at the earliest opportunity.

4. The Patient Care Workgroup recommends that requirements for prior patient consent that exceed Federal minimums to deliver clinical information to treating clinicians be reduced or eliminated so as to increase the patient benefit from treating clinician access to comprehensive information at the point of service.
5. e-Prescribing should ideally:
 - Be integrated into the clinical workflow as part of an electronic medical record (EHR) system;
 - Utilize information from both the clinician EHR and from the regional Health Information Exchange to improve the quality of clinical decision support applications; and
 - Contribute information on prescribing and dispensing to the regional Health Information Exchange to enrich the quality and timeliness of exchange information.
6. While many early users may receive HIE information by fax or other technologies, it is critical that the data be increasingly standardized over time, such that it can be imported and exported automatically and used within EHRs and other applications. Similarly, it is important that clinicians and others continue to invest in EHRs and other forms of HIT that are certified to meet such interoperability goals. The availability of standardized information feeds from an HIE and the certification of interoperable applications are likely to accelerate adoption of technology in the practice setting, and vice versa.
7. Five-year goals for end-user technology include:
 - Universal high-speed Internet access for health care providers, service providers, and other professional stakeholders;
 - Affordable EHR systems capable of importing and exporting the priority data set accessible to all clinical providers (This is likely to emerge in part by Internet-served applications that reduce installation, maintenance, network administration and lifecycle costs for smaller practices.); and
 - Patients should have universal access to high-speed Internet in their community, if not in their home.

8. Most information exchange should be developed at the regional (sub-state) level by Regional Health Information Organizations serving market-defined Medical Trading Areas.
9. Inside Wisconsin a statewide organization could provide the following services (particularly if state government were an active participant):

Assuring and assisting regional HIEs to utilize common standards for data transmission, vocabulary and other key functions to permit exchange of information between and beyond Wisconsin HIEs as needed.

- Leveraging existing or future statewide information systems or data sets to help regional HIEs implement foundational infrastructure, such as secure user identity management, master patient indexing, or record locating services. For example, a state licensing and registration system could be used to help validate clinical users, or the statewide immunization registry could provide information useful for creating a regional master patient index.
 - Obtaining, standardizing and providing for regional HIE use data sets created by state government or other statewide entities (for example, immunization and disease registries, and Medicaid claims information). Access to such information could be obtained by purchase, by policy or a combination of the two.
 - Obtaining and providing (benefited by larger-scale purchasing power) data sets created by national or other large scale organizations (for example, national laboratories or the RxHub pharmacy benefit data hub). Access to such information could be obtained by purchase, by policy or a combination of the two.
 - Managing requests for information between regional HIEs: for example, when a patient requires care outside her home region and her provider seeks historical information.
 - Managing interactions between regional HIEs and the Nationwide Health Information Network (NHIN).
10. Regional HIEs should pursue incremental development of exchange services, focusing initially on those that build foundational infrastructure needed for later, more advanced exchange services. Early services and products should also be selected on the basis of a sustainable business model that creates a foundation of revenue and trust for later service expansions.

11. Emerging HIE initiatives should seriously consider implementing result delivery and clinical document delivery as early exchange services, because these build foundational infrastructure, stakeholder trust and sustainable revenue flow and administrative savings to support additional, later exchange projects.
12. In regard to HIT adoption:
 - a. The DOQ-IT program for adoption of electronic medical records should be supported and expanded. The focus should expand it to include specialty practices in addition to primary care.
 - b. Wisconsin should ultimately subsidize only HIT which is CCHIT-certified and adhere to AHIC (and possibly narrower Wisconsin) standards.
 - c. Wisconsin should address workforce issues to assure success of HIT adoption efforts.

Information Exchange Workgroup – Executive Summary

Health information technology (HIT), including electronic health records (EHR), and health information exchange (HIE) provide opportunities to improve quality, increase efficiency, and improve the return on investment in health care. These technologies also present opportunities to strengthen knowledge about disease, treatment, and effectiveness of health care. To reach their full potential, these technologies must be implemented in a manner that assures consumers that electronic access to their personal health records will not compromise privacy or permit misuse.

The Information Exchange Workgroup recognized that Wisconsin has an existing set of health information services that uniquely position the state to leverage health information exchange. Nationally, single-physician practices represent approximately 38% of all practices, whereas in Wisconsin this number appears to be about 7% and shrinking. This suggests Wisconsin may be uniquely positioned for rapid growth in physicians' access to electronic medical record systems (compared to the national distribution of physician practice size).

Underlying Principles

The Information Exchange Workgroup agreed to endorse the Markle Foundation's Common Framework for guidance in establishing health information exchange technology and policy¹:

- a. Technology Principles
 - i. It is preferable to implement a "Thin" network (defined as a simple client program or device designed to be especially small so that the bulk of the data processing occurs on the server), but for flexibility a hybrid or centralized data architecture may be needed to satisfy workflow or implementation requirements.
 - ii. Avoid "Rip and Replace"
 - iii. Separate Applications from the Network
 - iv. Decentralization
 - v. Federation
 - vi. Flexibility
 - vii. Privacy and Security
 - viii. Accuracy
- b. Policy Principles

¹ For further elaboration of Common Framework principles see <http://www.connectingforhealth.org/commonframework/#guide> (accessed 10-6-06).

- i. Openness and Transparency
- ii. Purpose Specification and Minimization
- iii. Collection Limitation
- iv. Use Limitation
- v. Individual Participation and Control
- vi. Data Integrity and Quality
- vii. Security Safeguards and Controls
- viii. Accountability and Oversight

Recommendations

1. Adopt the Markle Foundation's Common Framework guiding principles listed above.
2. Leverage existing assets for the utility functions that will be provided at the regional and/or statewide level through the examination of state resources and private initiatives for opportunities to further the adoption of both HIT and HIE. Significant work has been done through public and private enterprises to establish health IT infrastructure services that could accelerate deployment of health information exchange. The services include the ability to uniquely identify patients, extensive health information repositories to support both clinical care delivery and the state's public health mission, and groundbreaking public/private sector initiatives to establish an IT-enabled health care quality measurement infrastructure.
3. Expand broadband access to areas around the state through promotion of the BadgerNet Converged Network (BCN), which unites the separate data and video networks.
4. Drive HIT adoption and develop HIE simultaneously.
5. Conduct further analysis on possible tax breaks and incentives to ensure that small providers are not forced out of the exchange, and if provided, tie financing to adoption of products that are consistent with national requirements (i.e., Health Information Technology Standards Panel (HITSP) standards, Certification Commission for Health IT (CCHIT) certification) for emerging Wisconsin health information exchanges.
6. Promote HIT adoption among small and rural providers by:
 - Promoting applications that are thin, complete EHR systems;
 - Ensuring that costs associated with the exchange do not place an undue burden on small volume facilities.

- Developing a means to assist these entities in interfacing with the exchange (funding and technical assistance);
 - Allowing for a flexible flow of clinical information that does not force small hospitals into predetermined data exchanges where large hospitals and their outreach programs accrue the benefits.
7. Given the broad mix of hospital and physician practice HIT density in the state, as well as the unique health care delivery economics in the various rural and urban settings, facilitate and optimize health information exchange based on the needs of the local communities through the creation of Regional Health Information Organizations (RHIOs) – starting with information about allergies, medications, and diagnoses through a local/regional health information exchange.
8. Provide incentives such as start-up funds or technical assistance to develop up to five RHIOs in Wisconsin (considering factors such as minimum populations served or organized consistent with existing medical trading area patterns ²).
9. Require that all Wisconsin RHIOs meet minimum requirements including:
- Population served (at least one million people in the geographic area it covers);
 - Alignment with natural medical trading areas;
 - Willingness to serve all members of the communities in the designated area – cannot be vendor-driven or exclusive;
 - Independent with broad governance including both public and private sector representatives and strong consumer representation; and
 - Administrative competency on EHRs.
10. Develop a set of statewide health information exchange services to:
- Serve as the link between RHIOs, other states, and the Nationwide Health Information Network (NHIN).
 - Provide basic utility-type services that are most effective at the state level and that can leverage existing state assets such as record location and user authentication services.

² The Dartmouth Atlas of Health Care in the Great Lakes States, <http://www.dartmouthatlas.org/atlas/region4.pdf>, accessed on October 31, 2006.

- Improve the ease, quality and effectiveness of state-hosted health information systems to exchange patient information with existing provider HIT systems.
 - Provide basic patient information to providers that do not have access to a regional health information exchange.
 - Provide practice guidelines/clinical decision support for health care providers.
 - Provide a Web portal for consumers to obtain health education materials and practice guidelines.
 - Research and resolve policy issues that are barriers to health information exchange.
11. Adopt hybrid architectural models in which some data is centralized and other information is stored at locations where care is provided. Data providers have a choice of maintaining constant access to their own data servers or allowing their data to be stored in a central location for retrieval. This model allows for the greatest flexibility for data providers. This will minimize the concerns related to trust and allow centralization for timeliness in accessing the information when needed.
12. Determine the preferred method for establishing a master person/patient index to uniquely identify the correct patient with high accuracy, as a key to secure a uniform exchange, at the highest level possible. This will ensure the provider accesses the right information about the right patient, increasing confidence in the exchange and improving patient care.
13. Provide policies for auditing and security at the local level. These policies should ensure appropriate access is being provided at the local level; compliance should dictate when the organizations are to be included in the exchange. The workgroup noted that this may result in a financial burden for small provider groups and clinics, but that it also allowed for more local control.
14. Focus security at the local level. The workgroup discussed the concept of imposing the most stringent security upon all participants in the exchange. Due to the challenge this could impose on small organizations, the group recommends further examination of how this is addressed in other states, with the assumption that the current HIPAA requirements would be the minimum security level.

15. Adopt the following phasing structure to accelerate clinical information exchange access and use by health care professionals near-term while recognizing and planning for incremental enhancements to both clinical information breadth and depth.

Phase 1: Share Care Status Information: Includes clinical messaging of information like lab results, diagnostic imaging reports, discharge summaries, and correspondence including structured medical summaries available from clinical EHR systems to support transition or continuity of care among providers; enables shared views of encounters, results and medications from sources like pharmacy benefit managers, claims data, immunization summaries, etc.

Phase 2: Share highly structured and standardized information for import/export by HIT applications including order entry, e-prescribing, patient-managed (PHR) information, and images.

Phase 3: Advanced Clinical Support and Advanced Access Control: Extends information access control in more sophisticated ways (roles and context-sensitive access, patient-managed controls); and enables dynamic queries of structured information by clinical decision support systems and other applications (algorithms to improve safety, quality, value and public health protection).

Phase 4: Collaborative Care, Active Quality Reporting and Health Surveillance: Deepen workflow-oriented collaborative services, such as e-visits, electronic referrals, and future generations of real-time interaction between clinicians, service providers, patients, public health, care managers, quality and safety initiatives.

16. Complete a more comprehensive survey of HIT in Wisconsin targeting a broader audience than the one completed by MetaStar in 2005 as a means of providing an accurate representation of statewide HIT adoption.
17. Based on recommendations from the Consumer Interests Workgroup and technology complexities associated with the current policy, the Information Exchange Workgroup suggests the following changes to state policy:
 - a. Allow redisclosure of patient information between providers for care purposes without explicit patient consent. Currently, if one provider sends patient information to another, the provider receiving that information cannot redisclose that information without explicit patient consent.
 - b. Develop policy recommendations that address the need for health information exchange to support the need for parents, caregivers, and

- other patient advocates to facilitate the movement of health information as needed for those in their care.
- c. Give careful consideration to redesigning enforcement for special-protection data, such as mental health, HIV testing, etc.
18. Wherever possible, encourage the RHIOs to develop a mapping or card catalog method that would allow for segregation of health information and demographic information. Examples include the Connecting for Health Record Locator Service and the Integrating the Healthcare Enterprise (IHE) Cross-Enterprise Document Sharing (XDS) models.
19. Adopt standards and interoperability specifications developed by the Health Information Technology Standards Panel (HITSP) to facilitate the exchange of information across systems, and make these a condition for entities to participate in the HIE. Where possible, state government should use its ability to leverage its contracts for health care technology to promote the use of these standards and interoperability specifications.
20. Because health care technology and exchange are new concepts, develop infrastructure that is flexible, accessible, scalable, adaptable, and replicable. As part of this effort, employ open standards, so interoperable systems are designed. National policy should drive these standards, but if there is a need, develop additional standards at the state level.
21. Establish a multi-stakeholder panel to make recommendations to the Board regarding national health information exchange initiatives and their impact on the state's roadmap.
22. Promote e-prescribing as a visible, near-term example to consumers of how HIT can improve patient safety, convenience, and consumer empowerment, and leverage its use to accelerate broader HIT adoption in the ambulatory care setting.

Next Steps

The Information Exchange Workgroup made significant progress towards its assignments. As implementation activities begin, it will be necessary to consider the following activities:

- Finalize recommendations on architectural requirements.
- Identify a minimum set of standards to support recommendations and an initial set of business opportunities for the advancement of HIT.

- Continue to monitor and coordinate activities with the Nationwide Health Information Network pilot program, related HITSP interoperability, and other national efforts that may influence ongoing HIE technology planning and implementation.
- Continue to identify and promote use of appropriate existing state information technology assets to increase the value of information exchange for both private and public sector health care delivery.
- Continue discussion on the role of the patient in accessing his/her own health information.
- Prioritize the use cases developed by the Patient Care Workgroup that would have the most impact and create technical requirements for their implementation.
- Establish criteria for a qualitative analysis of the HIT density indicators, such as levels of system adoption.
- Expand the HIT density study to include:
 - a. Indicators to include additional HIT systems.
 - b. All hospitals in Wisconsin.
 - c. Out-of-state hospitals, in order to determine whether the Wisconsin experience is characteristic or anomalous.
- Expand the HIT density study to determine status of HIT linkages between rural hospitals and public health immunization registers and other population health initiatives.

Consumer Interests Workgroup – Executive Summary

SUMMARY OF RECOMMENDATIONS

Accurate, understandable information is critical to high quality health care and improved population health. Electronic health records (EHR), health information technology (HIT), and health information exchange (HIE) provide opportunities to empower consumers and ensure robust patient data are available to providers at the point of treatment, dramatically improving both quality and efficiency of care. HIT and HIE also enable enhanced monitoring of the individuals and entities that access patient health information, serving as a double-check to patient privacy. As well, these technologies present opportunities to strengthen knowledge about disease, treatment, and effectiveness of health care. Some consumers have expressed concerns that patient information within EHRs and HIE will be misused. These recommendations reflect the Consumer Interests Workgroup's efforts to balance the benefits of HIT/HIE with privacy concerns to achieve optimal patient care.

Underlying Principles

The Consumer Interests Workgroup has adopted the principles below as the foundation for each charge listed in their charter. These principles were developed by the Markle Foundation's Personal Health Technology Council.

1. Individuals should be able to access their health and medical data conveniently and affordably.
2. Individuals should be able to designate someone else to have access to and exercise control over how their records are shared.
3. Individuals should receive easily understood information about all the ways that their health data may be used or shared.
4. Individuals should be able to review which entities have had access to their personal health data.
5. Electronic health data exchanges must protect the integrity, security, privacy, and confidentiality of an individual's information.
6. Independent bodies, accountable to the public, should oversee the electronic health data exchanges. No single stakeholder group should dominate these oversight bodies. Consumer representatives selected by their peers should participate as full voting members.

Actions and Recommendations

Charge 1: *Understand consumer expectations regarding electronic health data exchange.*

The workgroup undertook an extensive review of national surveys and literature capturing consumers' views of HIT, HIE, and EHR. In addition, the group organized a listening session for Wisconsin advocacy groups and consumers. These efforts captured consumer support for a transition from paper health records to EHR and HIT as well as concern about the privacy, security, and confidentiality of personal health information in an electronic environment. Privacy concerns were most notable for more sensitive types of health information, particularly mental health and domestic violence. Research and discussion of consumer expectations set the stage for consideration of all other charges.

Charge 2: *Identify HIE and HIT outcomes that are highest priority from the consumer perspective.*

The Consumer Interests Workgroup identified the following outcomes as its highest priorities:

- Improved patient care through appropriate consumer and provider access to health information and evidence-based decision support.
- Privacy, security, and confidentiality of personal health information.
- Improved communication among all parties relevant to patient care.
- Improved consumer understanding of patient rights, responsibilities, and benefits associated with personal health information and health information exchange.
- Increased patient participation in decision-making regarding one's own health, health care, and health information.

The group also noted the importance of reliable and accurate identity verification mechanisms supporting health information exchange: poor identity matches can result in inadvertent disclosure of personal health information and substantially increase the risk of medical errors.

Charge 3: *Define acceptable and unacceptable data use policies to maintain privacy and security, including agreements for patient consent and use of data.*

- **Rec. 3.1:** Personal health information should be included in an exchange available to health care providers for treatment purposes; patients should not be able to opt-in to, or out of, this exchange.

- **Rec. 3.2:** Data use policies should: (1) balance patients' right to privacy with providers' need to access health information to provide optimal care; and (2) differentiate among the areas delineated by HIPAA (treatment, health care operations, payment, research, and public health).

Charge 4: *Make recommendations on whether health information with special protections will be included in electronic health data exchange.*

- **Rec. 4.1:** The Wisconsin legislature should amend Wisconsin law governing disclosure of health information to providers to be consistent with HIPAA, which does not require patient consent to disclose information to providers about mental health and developmental disabilities for treatment purposes. This recommendation:
 - Aims to improve providers' ability to give patients optimal care;
 - Increases Wisconsin's potential to participate in multi-state exchanges for treatment; and
 - Rests on the assumption that participating organizations have security measures that sufficiently protect all personal health information.

While this recommendation goes forward, it was not unanimously supported. Some workgroup members expressed concerns about stigma, potential bias in care, and patients withholding information to the detriment of their health and health care.

- **Rec. 4.2:** The Wisconsin legislature should review Wisconsin Statutes protecting patient rights and revise them as necessary to ensure that any provider or entity that provides unfair or inappropriately discriminatory treatment is subject to severe penalties.
- **Rec. 4.3:** The Wisconsin legislature should review Wisconsin Statutes protecting patient rights and revise them as necessary to ensure that any provider or entity that deliberately or inadvertently mishandles, inappropriately shares, or inappropriately distributes personal health information is subject to severe penalties. Penalties should reflect the egregiousness of the act.
- **Rec. 4.4:** Health information exchanges must protect the integrity, security, privacy, and confidentiality of all personal health information and recognize that some types of information are especially sensitive. Thus, organizations participating in exchange should consider appropriate *additional* technical and/or procedural safeguards for more sensitive types of health information.

Charge 5: *Define acceptable and unacceptable data use policies for oversight purposes, including public health and research.*

The recommendations below apply specifically to data used for public health and research purposes. Policies governing data use for other oversight purposes, (e.g., quality improvement, health care operations, safety initiatives, utilization review, etc.) should be discussed in the next phase of Wisconsin's eHealth Initiative.

- **Rec. 5.1:** Data use agreements and policies that support HIE should ensure that: (1) all reports and publicly available data sets resulting from provider-submitted identifiable data continue to include only de-identified data; and (2) strict controls continue to govern access to, and use of, reported data.
- **Rec. 5.2:** Designated public health entities should support and leverage new capabilities available through HIE and electronic reporting to improve the health of the public.
- **Rec. 5.3:** As new data sources emerge, policies governing access to health care data for research purposes should consider the original purpose of data collection, such as: data captured by providers at the point of care, held by an HIE, or collected explicitly for research purposes.

The group also noted that designated public health entities' ability to collect identified personal health information for statutorily mandated purposes will be enhanced as a result of HIE.

Charge 6: *Define guidelines and examples that clarify how data sharing can balance the requirement to protect privacy and security with the need to share information to improve care.*

Wisconsin's eHealth Initiative is in the process of identifying privacy and security policies and practices that may impact the exchange of health information as part of the national Health Information Security and Privacy Collaboration (HISPC) project. These activities will form the basis for the selection of real-world examples that best demonstrate how data sharing can balance patient privacy and system security with the need to share information to improve patient care.

Charge 7: *Identify options to help consumers manage their own health care, advocate for themselves, and support mutual accountability for health.*

- **Rec. 7.1:** Holders of personal health information should ensure that individuals are able to conveniently and affordably access their health information, including which entities have had access to this information.

- **Rec. 7.2:** The state should undertake an education campaign that communicates the purpose, capabilities, and system safeguards of exchange as part of Wisconsin's eHealth Action Plan. Education materials and activities must be easily understandable and accessible for Wisconsin consumers regardless of health literacy, reading skill, computer proficiency, or geographic location. Materials and activities must appropriately address the language, educational, and cultural needs of consumers of all backgrounds (be culturally competent) and be easily accessible for all Wisconsin residents.
- **Rec. 7.3:** All relevant stakeholders should share financial responsibility (costs) and benefits (savings) affiliated with HIT and HIE.
- **Rec. 7.4:** Consumer representatives should have roles equal to those of other stakeholders in the ongoing governance of Wisconsin's HIE activities.
- **Rec. 7.5:** The state should raise consumer awareness of personal health records (PHRs) as a mechanism to manage one's health and health care.

Charge 8: *Identify legal actions required for the priorities recommended by the clinical work team.*

- **Rec. 8.1:** The Wisconsin legislature should amend Wisconsin law governing disclosure of health information to providers for treatment purposes to be consistent with HIPAA. (Charge #4)
- **Rec. 8.2:** The Wisconsin legislature should review Wisconsin Statutes protecting patient rights and revise them as necessary to ensure that any provider or entity that provides unfair or inappropriately discriminatory treatment is subject to severe penalties. (Charge #4)
- **Rec. 8.3:** The Wisconsin legislature should review Wisconsin Statutes protecting patient rights and revise them as necessary to ensure that any provider or entity that deliberately or inadvertently mishandles, inappropriately shares, or inappropriately distributes personal health information is subject to severe penalties. Penalties should reflect the egregiousness of the act. (Charge #4)
- **Rec. 8.4:** The Wisconsin legislature should amend law to support electronic reporting of health related data to statutorily identified entities. (Charge #5)
- **Rec. 8.5:** As Wisconsin's eHealth Initiative moves forward with the HISPC project and other eHealth activities, the eHealth Board should

monitor potential impacts on Wisconsin Statutes and recommend changes as warranted.

Charge 9: *Fulfill responsibilities required by the state's contract with Research Triangle International (RTI) for the Health Information Privacy and Security Collaboration (HISPC).*

The first two phases of the HISPC project are complete. Two volunteer workgroups, *Variations* and *Legal*, reviewed scenarios designed by RTI and highlighted potential procedural and legal challenges to health information exchange. A number of Consumer Interests Workgroup members were active participants in both workgroups. Consumer Interests Workgroup members will continue to play an active role in the *Solutions* and *Implementation* phases of the HISPC project.

Next Steps

The Consumer Interests Workgroup has made significant progress towards each of its charges and has initiated dialogue with individual consumers and consumer groups. As Wisconsin advances towards adoption and implementation of interoperable electronic health records, it will be crucial for the eHealth Board to continue engaging consumers and their advocates in constructive, open discussions. The following activities should also be high priorities for the eHealth Board in the next stages of Wisconsin's eHealth Initiative:

1. Define specific recommended guidelines and real-world examples that clarify how data sharing can balance the requirement to protect patient privacy and system security with the need to share information to improve patient-centered care.
2. Develop recommendations for actions that will prevent breaches of privacy, security, or confidentiality of patient health information, within organizations and in the exchange of information among organizational systems, as well as remedies for any breaches that occur.
3. Develop specific mechanisms to accommodate patient concerns and complaints related to health information exchange.
4. Build understanding of, and support for, health information exchange among consumers and health care providers through education efforts.
5. Guide implementation of the consumer interests and privacy components of the eHealth Action Plan; assess and report on progress annually.

6. Develop policy statements and recommendations regarding use of health information for purposes other than treatment (e.g., patient safety initiatives, quality improvement, health care operations, payment, law enforcement, etc.)
7. Develop policy statements and recommendations that empower consumers to manage their health, health care, and health information.
8. Oversee preparation of final reports for the Health Information Security and Privacy Project.

Financing Workgroup – Executive Summary

The business case for the adoption of health information technology (HIT) and participation in health information exchange (HIE) lies in promises of improved clinical processes and workflow that lead to safer, higher quality care, reduced administrative expenses, decreased clinical and administrative redundancies and improved coding. The system as a whole promises a more robust ability to report measures of quality and track outcomes. This will in turn strengthen purchasers' ability to design value-based purchasing that pays for quality – the truest return on investment for this endeavor.

But these goals will require substantial up-front investments in electronic health records (EHRs) and their interoperability among providers. To date, despite great promise and ambitious national plans, EHR adoption rates remain low, with less than 20% of U.S. physician practices fully automated, and only about half of hospitals even partially so. Fully operational health information exchange requires that HIT penetrate beyond physician offices and hospitals, pharmacies and laboratories, to include long-term care facilities and local health departments.

Wisconsin has a number of strengths that are likely to place it somewhat ahead on the natural curve of technology adoption: More than half of Wisconsin's physicians practice in large integrated group practices. Wisconsin is home to industry leaders in the arena of electronic medical records and HIT. Pioneering efforts are underway through the Wisconsin Collaborative for Healthcare Quality (WCHQ), Wisconsin Health Information Organization (WHIO), the Wisconsin Hospital Association's Checkpoint program, and four demonstration projects supported by grants from the federal Agency for Healthcare Research and Quality (AHRQ).

Nonetheless, to many physicians, the business case remains uncertain. Current reimbursement policies pay for diagnostics and treatment, not for outcomes or the handling of information; the gains in quality or reductions in cost are likely to first accrue to payers and purchasers. As well, small practices simply lack the \$20,000-\$40,000 per physician in up-front investment capital and lost productivity needed to acquire and start-up an EHR system. Beyond physicians, advanced connectivity among the range of providers is an essential goal of the Wisconsin and national eHealth initiative, and will most certainly require significant investments.

National estimates of the costs to deploy HIT and HIE across the entire spectrum of health care in the U.S. range from \$115 billion for the HIT costs³ to \$156

³ Hillestad, R, Bigelow J, Bower A, *et al.* Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs. *Health Affairs* Sept/October 2005 Vol. 24(5):1103-1117.

billion for the connectivity infrastructure required for a Nationwide Health Information Network,⁴ to \$276 billion for all providers to achieve full HIE.⁵ This suggests, through crude estimates allotting Wisconsin 2% of these costs in proportion with its share of the U.S. population, a need for \$2.3 billion to as much as \$5.5 billion investment in Wisconsin.

More refined Wisconsin-specific financial projections depend on estimates of the current level of HIT adoption among Wisconsin's physicians and hospitals. Beyond this, statewide interoperability will require resources both to fill the adoption gap and to adapt current and legacy systems.

Assume for now a hypothesized 35% adoption gap among physicians and hospitals. Wisconsin would then require resources in the range of \$1 billion-\$2.8 billion to build a universal EHR and information-sharing infrastructure through regional health information organizations (RHIOs). Such resources could come through several venues.

Most of the funds for HIT acquisition, start-up, and maintenance will continue to come through private investment, particularly as HIT becomes part of standard medical practice and the baseline cost of doing business. As the market moves naturally in that direction, the prices for HIT should moderate. However, timely universal adoption and participation in HIT/HIE – including providers and facilities of all sizes and throughout the state – will require public and private sector seed money and incentives. As well, the success of this enterprise for all providers and their patients will require a continued redesign of payment systems to support value, quality, and outcomes.

The business case for HIT/HIE depends on support from multiple stakeholders. Purchasers may design pay-for-quality incentives for HIT adoption, with expectation about improved quality and more transparency to support value-based purchasing. Providers' business plan for HIT investment may rely on the hope of "billing optimization," which could be perceived by purchasers and payers as counter to their interests. Ultimately, stakeholder equity and the public good of reduced costs and improved quality will require that HIT go beyond what Sidorov and colleagues⁶ refer to as "simple engraftment into the current health care system" -- to include re-engineered processes along with concomitant changes in the current reimbursement model.

⁴ Kaushal R, Blumenthal D, Poon E, *et al.* The Costs of a National Health Information Network. *Annals of Internal Medicine* Vol. 143(3):165-173.

⁵ Walker J, *et al.* The Value of Health Care Information Exchange and Interoperability. *Health Affairs*, January 13, 2005. <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.10/DC1>, accessed November 30, 2006.

⁶ Sidorov J. It Ain't Necessarily So: The Electronic Health Record and The Unlikely Prospect of Reducing Health Care Costs. *Health Affairs* July/August 2006. Vol 25(4):1079-1085.

Financing Workgroup Goal: Develop options for funding electronic health records in all size health care settings and for the operation of a statewide public-private health information infrastructure.

Strategy: The best strategy for overcoming the barrier to HIT adoption is to increase the value proposition of EHRs.

Findings and Premises underlying Recommendations:

1. HIT/HIE is a public good and the investment in its development and operations should be partially funded from public sources.
2. Financing is needed for three levels of infrastructure: 1) appropriate HIT adoption and use by providers, 2) HIE through RHIOs or other exchange mechanisms at the regional level, and 3) statewide HIE.
3. A fully implemented HIE environment requires consistency of platforms and standards for inter-operability that do not yet exist, and must be developed at the national level.
4. Approach must be statewide, politically feasible, and consistent with federal initiatives.
5. The RHIO concept does not capture a standard set of information exchange activities or functions, and thus the acronym does not describe any specific model. Financing will need to target individual functions and step-wise, phased-in modular adoption of functions. The definition of the scope and functions of a state-level RHIO effort will determine the strategies for obtaining long-term sustainable financing.
6. Regional HIE can reduce the costs of system start-up as well as maintenance, through shared services and economies of scale.
7. Up-front subsidies may not support ongoing HIT use and investment. Ideally public and private reimbursement systems should be aligned to produce long-term return-on-investment (ROI), fostering long-term use of and continued investment in HIT and HIE, while preserving market price pressures on vendors. Nevertheless, assistance with short-term capitalization of HIT may be needed for low-margin safety-net providers.
8. The plan will require phase-in over time, but HIE promotion should not crowd out resources to bring all providers to a baseline level of capability for internal clinical and patient safety systems and the internal capture and aggregation of data. As well, incentives must not crowd out private sector market developments and within-enterprise investment priorities.

9. Any State incentives for adoption must recognize and reward the investments already made by early adopters/investors/pioneers while promoting broader diffusion of technology.
10. Marginal costs must, to the greatest extent possible, correspond with marginal benefits. This will vary by type of provider/constituent, but each stakeholder needs to realize a proportional ROI. The financial contributions to fund the initiative should be equitable among the key health care stakeholders (public/private as well as provider, payer and purchaser) and proportionate to the use/benefit.
11. The system requires re-engineering processes and workflow, and adoption phase-in will incur productivity costs.
12. HIE must accommodate existing efforts and incorporate legacy systems. New systems must avoid creating multiple login environments where HIT exists but interface capability is currently lacking. At the same time, existing initiatives will need to evolve to meet the promise of emerging technology.
13. Organizations - particularly low-volume unaffiliated – may need help financing and implementing EHR systems. Many rural hospitals in particular lack interface engines and interface expertise, and often have limited IT resources in house. They will need interfacing hardware, software, and expertise resources to participate in HIE.
14. Costs of participation in HIE need to be scaled for smaller rural communities, with consideration of the relative benefits in various markets.
15. HIE will allow for flexible flow of clinical data across systems and referral centers, rather than limiting access within existing referral relationships and proprietary networks.
16. The actual RHIOs will develop business plans and a clear value model for each HIE function they pursue, with specific capital and operating expenses and potential revenue sources identified.

A. Recommendations regarding the roles of the public and private sectors:

1. State government should use its leverage as a purchaser and payer to drive HIT adoption.

2. State government programs, including Medicaid, ETF, biosurveillance, and public health services, should tie in with the state-level HIE architecture rather than create stand-alone, parallel (silo) data systems. Integration of such programs into state and regional HIE can minimize redundancies and disruptions to clinical workflow. Savings and benefits should be returned to participants in the form of economic or other incentives for providers to adopt and participate in the system.
3. The eHealth Action Plan should leverage Wisconsin's strength and talent in the HIT industry to develop non-proprietary/open source EHR products, to improve the value of what is delivered, and to assist with customizing or adapting it for application.
4. The eHealth Action Plan should pursue EHR group purchasing strategies, as well as possible contributions from payers that are potential beneficiaries of providers' use of HIT.
5. Private industry, health care organizations and purchasers all have a key role in HIE development. Purchasers and payer organizations should develop and implement value-based purchasing strategies, including pay-for-quality programs that encourage HIT adoption and use. Such strategies must coalesce around common quality, value, safety and data standards.
6. Savings in one sector may need to be shared with others to overcome early mismatches between the costs and benefits of those joining the exchange.

B. Recommendations on specific funding sources:

The eHealth Financing Workgroup recommends that the Governor and legislature consider the following measures to support the goals of Wisconsin's eHealth Action Plan.

1. Revenue Bond:

- State Legislature authorize a call for officially designated RHIOs or like structures;
- RHIO would be eligible for financing HIE through state bonding authority;
- State must pay its proportionate share (ETF, Medicaid) if other sectors participate;
- Bond issue would be paid by users' revenue, not repaid by GPR.

- State should pursue the feasibility of a tax-exempt lease as a preferred financing approach.

2. Shared Services:

Wisconsin's eHealth Initiative, as a public-private collaboration, could coordinate/integrate key and necessary administrative and other activities that maximize efficiencies and reduce total cost/resource allocation across various initiatives. Among potential immediate opportunities for collaboration: legal, insurance, IT-data elements and architecture, HIPAA regulations, accounting, vendor RFP processes, evaluation, and acquisition.

3. Tax Credits and Exemptions:

The U.S. Department of Health and Human Services recently issued new regulations that relax the restrictions (known as Stark and anti-kickback rules) on donations of e-prescribing software and hardware to physicians. The Wisconsin legislature and Governor should consider adopting tax exemptions on donated IT systems consistent with these changes and with related federal tax exemptions. In addition, Wisconsin's and other states' legislatures have considered creating an income and franchise tax credit for health care providers in an amount that is equal to or some proportion of the amount that the health care provider pays in the taxable year for information technology hardware or software that is used to maintain medical records in electronic form. As well, Wisconsin might create an individual and corporate income tax exemption for interest on bonds or notes issued by the Wisconsin Health and Educational Facilities Authority for purposes related to the purchase of information technology equipment by health facilities.

4. Medicaid and ETF Incentive Payments

Several states around the country provide examples of the kind of leverage the State of Wisconsin might exert in its role as a major purchaser of health care services. For example, legislatures in Wisconsin and other states have considered directing state Medicaid agencies to make an annual incentive payment to hospitals that establish and maintain a physician order entry record system.

5. Blue Cross/Blue Shield Endowment:

Wisconsin's two medical schools, University of Wisconsin and Medical College of Wisconsin, are the stewards of the endowment funds that resulted from Wisconsin BC/BS conversion to a private shareholder corporation. These funds are guided by a five-year plan, approved by Wisconsin's Commissioner of

Insurance. The funds have developed a significant reserve. The next five-year plan is being developed and is scheduled to take effect in 2009.

- The eHealth Financing Workgroup recommends that the Insurance Commissioner and the two medical schools carefully study Wisconsin's eHealth Action Plan and consider strategic and programmatic investment opportunities, recognizing the goals and mission shared by the two enterprises.

C. Recommendations for targeted financing:

1. **Focus on smaller, rural, and safety net providers:** Direct resources to those stakeholders who must be engaged but who may lack the resources to contribute financially (safety net providers, FQHCs, RHCs, CAHs, local health departments).
2. **Action Plan Function Phase-In:** Treat solo and small-practice physician offices as a special case; pursue their conversion on a "special track" and special adaptation timeline basis.
3. **Demonstration Project Funds:** Provide funds for demonstration projects that model collaboration in HIT purchasing, support and information exchange.
4. **Focus on Early Wins:** Target investments first at functions that promise early wins, such as e-prescribing and disease registries.

The Wisconsin Department of Health and Family Services has begun taking steps in the direction recommended by this report. In October 2006 DHFS submitted a Medicaid Transformation Grant proposal to the federal Centers for Medicare and Medicaid Services (CMS) that includes three provisions consistent with the recommended eHealth financing strategy: 1) operational and technical assistance to advance the adoption of EHRs by safety net providers; 2) HIE focused on the Medicaid and General Assistance Medical Program (GAMP) populations in Milwaukee County, and 3) pay-for-quality incentives to encourage standard data collection and quality reporting.

Governance Workgroup – Executive Summary

The Governance Workgroup was created by the eHealth Care Quality and Patient Safety Board in May 2006 to develop an organizational and governance structure for statewide health information exchange and to assure good communication across stakeholders about the eHealth initiative and its expected benefits.

To implement a workable statewide HIE in the next five years, the project should have a credible identity and a means to dispose of the many problems, questions, obstacles, and differences of opinion that will surely arise. This requires a coherent structure so that there is coordinating authority and a home for problems.

Provider and public acceptance, support, and funding are essential. Wisconsin's eHealth Initiative will have a much better chance of getting acceptance and support (particularly federal support) if it is clear that a single entity with a diverse board of all key stakeholders (including the State) has responsibility and accountability for the HIE/HIT initiative.

An incremental process is expected as has occurred in Minnesota, Arizona and other states. This is a new enterprise still in its formative stages, it will take time to stabilize, and it is important to assure coherence and accountability so that plans can be executed. While this is all still in the formative stages, a diverse board of key stakeholders (namely the existing eHealth Board) is needed to retain overall responsibility; standing committees of the Board should be established to attend to the key functions.

The buy-in and ownership of the Legislature are needed as this initiative moves forward. At some point enabling legislation should be pursued – it need not be prescriptive and should provide some funding. If there is legislation it would be most helpful if it is very general instead of specific about things such as committee structure so there is flexibility to respond to new issues.

While it is important to build from work being done nationally, there is excellent work underway in Wisconsin that should not be slowed down while waiting for federal action. There are now many significant initiatives underway in Wisconsin to leverage health information to improve the quality and safety of health care. Some Wisconsin organizations are far ahead of what other states are trying to do and it is important to build from this base.

There is real added value to convene leaders, align interests, build synergy about how these various initiatives can come together, and to take ownership of the goals for health information exchange so that there is a coordinated and

systematic approach to improving health care quality and safety and reducing health care costs. This will build on the strengths that exist in Wisconsin and apply the best information available from around the country. The private-sector people who have acquired practical experience should be invited to guide development of the new statewide HIE to avoid “re-inventing the wheel” and build on what has already been done.

A pluralistic representative board with structured workgroups is a workable structure. While a large and diverse board is desirable in terms of broad stakeholder representation, implementation can be problematic under a large board. Therefore it is also important to have an executive committee whose members are committed to implementation and smaller subunits to oversee implementation (operations) and other key functions.

The committee structure that the eHealth Board established to develop the Action Plan for the Governor has worked very well and should form the basis for the future structure, with appropriate adjustments to reflect the move to implementation mode.

Summary of Recommendations

1. Establish a governance structure under the leadership of the current eHealth Board to oversee implementation of the *eHealth Action Plan*.
2. Review the current composition of the Board to determine if there is appropriate representation of stakeholder expertise and views for the implementation phase; if not, recommend to the Governor additional stakeholder groups to be represented on the Board.
3. Create five committees reporting to the eHealth Board to begin work in January 2007:
 - a. Executive Committee
 - b. Patient Care Advisory Group
 - c. Consumer Interests and Privacy Advisory Group
 - d. Public Health Advisory Group
 - e. Statewide Health Information Exchange Advisory Group
4. Assign state staff to provide or contract for specific statewide services in support of Health Information Technology (HIT) and Health Information Exchange (HIE), including these functions:

- a. Represent the interests of all citizens;
 - b. Convene, educate and facilitate public and private health information initiatives;
 - c. Administer funding;
 - d. Remove barriers to health information exchange;
 - e. Set statewide HIE policy and standards, including policies for HIT adoption;
 - f. Align health information initiatives within state government;
 - g. Provide technical assistance to local and regional HIE efforts;
 - h. Serve as bridge to the Nationwide Health Information Network (NHIN) and to other states;
 - i. Monitor developments with the many public and private health information initiatives underway to identify opportunities for collaboration and to minimize redundancy;
 - j. Develop and implement a communications and marketing plan;
 - k. Staff the eHealth Board and its committees; and
 - l. Support technology operations that are statewide in scope (based on recommendations of the Information Exchange Workgroup).
5. Align the assignments to these workgroups with the national agenda and work of the American Health Information Community (AHIC) so that Wisconsin is poised to act as national standards and prototypes are readied.
6. Align interests and work activities under the leadership of the eHealth Board across the significant health information initiatives that are underway or that will develop in Wisconsin to assure a coherent, whole-system approach to change.
7. Include language in the 2007 – 2009 Governor’s Budget to:
- a. Express the support of the Legislature for the goal of delivering health care that is safe, effective, patient-centered, timely, efficient and equitable;

- b. Charge the eHealth Board with the responsibility to lead the implementation of the Wisconsin *eHealth Action Plan*, which identifies the strategies and steps to be undertaken over the next five years to leverage health information technology and exchange to improve the quality and reduce the cost of health care in Wisconsin;
 - c. Require an annual report from the Board to the Legislature as well as the Governor; and
 - d. Direct the Department of Health and Family Service (DHFS) to provide staff support to the eHealth Board and its operations.
- 8. Conduct an annual assessment of the strengths and weaknesses of the governance structure and recommend changes if needed to assure an effective and responsive structure and to make assignments for the coming year.
- 9. Once the eHealth Implementation Plan is approved, address legal implications of the governance structure including the specific authority of government and operating rules for the eHealth Board to provide clarity on respective roles, including authority to execute contracts and apply for grants.
- 10. Develop a communications and marketing plan early in 2007 using models available from national organizations and other states; assign responsibilities related to the plan to the Operations staff, under the direction of the Statewide Health Information Exchange Advisory Group. Create opportunities for joint sessions with CEOs and CIOs of health care provider organizations as part of this communications plan.

